

| | | | | | |
|--|---|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2147ASC | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 03/06/2008 |
| NAME OF PROVIDER OR SUPPLIER PARKWAY AMBULATORY SURGERY CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 100 N GREEN VALLEY PARKWAY, SUITE 125 HENDERSON, NV 89074 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
| A 00 | INITIAL COMMENTS <p>This Statement of Deficiencies was generated as the result of a focus state licensure survey conducted at your facility on 3/6/08. The facility was found to be in substantial compliance with the regulations regarding this survey. No further action is necessary concerning this report. Please retain this copy for your records.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p> <p>The state licensure survey was conducted in accordance with Chapter 449, Surgical Centers for Ambulatory Patients, adopted by the State Board of Health effective 9-27-99.</p> | | A 00 | | |

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE